105 CMR 300.000: REPORTABLE DISEASES, SURVEILLANCE, AND ISOLATION AND QUARANTINE REQUIREMENTS

Section

300.001: Purpose

The purpose of 105 CMR 300.000 is to list diseases dangerous to the public health as designated by the Department of Public Health and to establish reporting, surveillance, isolation and quarantine requirements. 105 CMR 300.000 is intended for application by local boards of health, hospitals, laboratories, physicians and other health care workers, veterinarians, education officials, and recreational program health officials, food industry officials, and the public.

300.002: Authority

105 CMR 300.000 is adopted under authority of M.G.L. c.111, §§ 1, 3, 5, 6, 7, 94C, 109, 110, 110B, 111 and 112, and M.G.L. c. 111D, § 6.

300.003: Citation

105 CMR 300.000 shall be known, and may be cited, as 105 CMR 300.000: *Reportable Diseases and Isolation and Quarantine Requirements*.

300.020: Definitions

The terms used in 105 CMR 300.000 shall be interpreted as follows unless the context or subject matter clearly requires a different interpretation.

Airborne Precautions. Measures designed to reduce the risk of transmission of infectious agents that may be suspended in the air in either small particle aerosols or dust particles. Patients in health care facilities must be given a private room with special air handling and ventilation (negative pressure), and respiratory protection is necessary when entering the patient's room.

Carrier. An individual who can tolerate an infection so as not to become ill, yet is able to transmit a disease-causing organism to cause infection and illness in others.

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Case or Patient. One who is ill, infected, injured or diagnosed with a reportable disease or injury.

Communicable. Ability of an infection to be transmitted from one person or animal to another.

Contact. A person who has been in such association with an infected person or animal or with a contaminated environment as to have had exposure capable of transmitting the infection to that person.

Contact Precautions. Measures designed to reduce the risk of transmission of infectious agents that can be spread through direct contact with the patient or indirect contact with potentially infectious items or surfaces. Gloves and gowns are required for all patient contact and contact with the patient's environment; strict hand hygiene practices must also be applied.

Counseling. Process by which individuals and groups learn to promote, maintain and/or restore health. Methods and procedures used in counseling must take account of the ways in which people develop various forms of behavior, of the factors that lead them to maintain or to alter their acquired behavior, and of the ways in which people acquire and use knowledge.

Date of Last Exposure. That point in time when exposure that would be expected to provide an opportunity for transmission of infection between a case or carrier and a susceptible person ends, or point in time when a case or carrier is no longer capable of transmitting illness or infection to others, whichever was more recent.

Department. The Massachusetts Department of Public Health.

Droplet Precautions. Measures designed to reduce the risk of transmission of infectious agents via large particle droplets that do not remain suspended in air, usually generated by coughing, sneezing or talking. Masks must be used, but gowns, gloves and special air handling are not needed.

Enteric Precautions. Measures designed to prevent direct or indirect fecal-oral transmission of disease. Gowns shall be worn if soiling is likely, and gloves shall be worn for touching contaminated materials; strict hand hygiene practices must also be applied. Masks are not indicated.

Food. Any raw, cooked or processed edible substance, ice, beverage, medications, or ingredient used or intended for use or for sale in whole or in part for human consumption via the alimentary tract.

Food Handler. Any person directly preparing or handling food. This could include the owner, individual having supervisory or management duties, person on the payroll, family member, volunteer, person performing work under contractual agreement, or any other person working in a food handling facility. Any person who dispenses medications by hand, assists in feeding, or provides mouth care shall be considered food handlers for the purpose of 105 CMR 300.000. In health care facilities, this includes those who set up trays for patients to eat, feed or assist patients in eating, give oral medications or give mouth/denture care. In day care facilities, schools and community residential programs, this includes those who prepare food for clients to eat, feed or assist clients in eating or give oral medications.

Food Handling Facility. Any fixed or mobile place, structure or vehicle, whether permanent, seasonal or temporary, in which food is prepared, processed, stored or held for sale, whether at retail or wholesale, or for service on the premises or elsewhere, or where food is served or provided to the public with or without charge. This term does not include private homes where food is prepared or served for individual family consumption.

Food Handling Facility Employee. Any person directly preparing or handling food. This could include the owner, individual having supervisory or management duties, person on the payroll, family member, volunteer, person performing work under contractual agreement, or any other person working in a food handling facility. In health care facilities, this includes those who set

up trays for patients to eat, feed or assist patients in eating, give oral medications or give

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mouth/denture care. In day care facilities, schools and community residential programs, this includes those who prepare food for clients to eat, feed or assist clients in eating or give oral medications.

Food Poisoning. Poisoning that results from eating foods contaminated with toxins. These toxins may occur naturally, as in certain mushrooms or seafoods; they may be chemical or biologic contaminants; or they may be metabolic products of infectious agents that are present in the food.

Health Care Provider. As defined in M.G.L. c. 111, § 1: "any doctor of medicine, osteopathy, or dental science, or a registered nurse, social worker, doctor of chiropractic, or psychologist licensed under the provisions of M.G.L. c. 112, or an intern, or a resident, fellow, or medical officer licensed under M.G.L. c. 112, § 9, or a hospital, clinic or nursing home licensed under the provisions of M.G.L. c. 111 and its agents and employees, or a public hospital and its agents and employees."

Health Care Worker. One who provides direct care to patients or who works in a setting where such care is provided.

Immunity. Possession of protective antibodies or cellular components sufficient to protect from infection and/or illness following exposure to an infectious agent (see also Resistance).

Incidence. A general term used to characterize the frequency of new occurrences of a disease, infection, or other event over a period of time and in relation to the population in which it occurs. Incidence is expressed as a rate, commonly the number of new cases during a prescribed time in a unit of population. For example, one may refer to the number of new cases of tuberculosis per 100,000 population per year.

Invasive Infection. Infection involving the bloodstream or internal organs, not including infection of the skin or mucous membranes. Invasive infection is usually established by the recovery of an etiologic agent from a usually sterile body fluid or tissue.

Isolation. Separation, for the period of communicability, of infected persons from others in such places and under such conditions as will prevent the direct or indirect transmission of an infectious agent to susceptible people or to those who may spread the agent to others. This applies also to animals (compare Quarantine).

Laboratory. A facility or place, however named, the purpose of which is to make biological, serological, chemical, immuno-hematological, cytological, pathological, or other examinations of materials derived from a human body. This includes laboratories in hospitals and other facilities.

Laboratory Test Diagnostic of HIV Infection. A laboratory test approved for clinical use by the U.S. Food and Drug Administration that indicates the presence of antibody to HIV, HIV structural components, or HIV ribonucleic acid in blood and other body fluid.

Non-name Reporting System. A department-designed reporting system for cases of infection with human immunodeficiency virus (HIV) that contains no patient identifying information and protects the confidentiality of the patient in compliance with M.G.L. c. 111, § 70F.

Outbreak or Cluster. The occurrence in a community, facility, workplace or region of cases of an illness clearly in excess of the number of cases usually expected. The number of cases indicating an outbreak or cluster will vary according to the infectious agent or the site conditions/hazards, size and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence. Outbreaks or clusters are therefore identified by significant increases in the usual frequency of the disease in the same area, among the specified population, at the same season of the year.

Personal Surveillance. The practice of close medical or other supervision of contacts without restricting their movements in order to promote prompt recognition of infection or illness.

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Prophylaxis. The administration of a drug or biologic agent to prevent the development of an infection or limit the progression of an infection.

Quarantine. Restricting the freedom of movement of well persons or domestic animals who have been exposed to a communicable disease for a period of time relating to the usual incubation period of the disease, in order to prevent effective contact with those not so exposed (compare Isolation).

Report of a Disease. An official notice to the appropriate authority of the occurrence of a specified disease in people or animals, directly by telephone, in writing, by facsimile, or by electronic means.

Resistance. The sum total of body mechanisms which interpose barriers to the progress of invasion or multiplication of infectious agents or to damage by their toxic products.

(1) Immunity is that resistance usually associated with possessing antibodies or cells having a specific activity against the etiologic agent of an infectious disease. Passive immunity is attained either naturally by maternal transfer or artificially by introducing specific protective antibodies. Passive immunity is of brief duration. Active immunity is attained by infection, with or without symptoms, or by introducing certain fractions or products of the infectious agent or the agent itself in a killed, modified or variant form.

(2) Natural resistance is the ability to resist disease independently of antibodies or a specific cellular response. It commonly rests in anatomic, cellular or physiologic characteristics of the host. It may be genetic or acquired, permanent or temporary.

Risk. The probability of an individual developing a given disease or experiencing a change in health status over a specific period of time.

Standard Precautions. Refers to consistent and prudent preventive measures to be used at all times regardless of patient's infection status. The Department adopts, by reference, as standard precautions for infection control, the most current version of the guidelines on the prevention of transmission of infection published by the U.S. Centers for Disease Control and Prevention and its Healthcare Infection Control Practices Advisory Committee.

Surveillance of Disease. Monitoring the occurrence and spread of disease and indications of such occurrence and spread.

Susceptible. A person or animal not possessing resistance to a pathogenic agent. Such a person or animal is liable to contract a disease if or when significantly exposed to such agent.

Suspect Case. A person or animal with clinical and/or laboratory evidence suggestive of the existence of a disease or condition dangerous to the public health but prior to the confirmation of such a diagnosis.

Unusual Illness. An illness, by any indication, occurring for the first time or under rare circumstances, or an illness associated with signs and symptoms not otherwise expected to occur based on the known or presumed etiology of the illness.

Work-related Disease. A disease or condition which is believed to be caused or aggravated by conditions in the individual's workplace.

Work-related Serious Traumatic Injury to a Person Less Than 18 Years of Age. An injury to a person less than 18 years of age which:

(1) results in death, hospitalization, or, in the judgment of the treating physician, results in significant scarring or disfigurement, permanent disability, significant loss of consciousness, or loss of a body part or bodily function; or which

(2) the physician determines is less significant but is of the same or similar nature to injuries previously sustained at the same place of employment.

Zoonotic. Infectious disease of animals that can be transmitted to humans.

300.100: Diseases Reportable to Local Boards of Health

Cases or suspect cases of the diseases listed below shall be reported by household members, physicians and other health care providers as defined by M.G.L. c.111, § 1, laboratories and other officials designated by the Department, by telephone, in writing, by facsimile or other electronic means, as deemed acceptable by the Department, immediately, but in no case more than 24 hours after diagnosis or identification, to the board of health in the community where the case is diagnosed or suspect case is identified. When available, name, date of birth, age, sex, address, place of employment, school and disease must be included for each report. The local board of health's responsibility, upon receipt of a report, is set forth in 105 CMR 300.110 and 300.160.

Amebiasis
Anthrax
Arbovirus infection, including but not limited to, infection caused by dengue, Eastern equine encephalitis virus, West Nile virus and yellow fever virus
Babesiosis
Botulism
Brucellosis
Calicivirus infection, including but not limited to gastroenteritis caused by Norwalk and Norwalk-like viruses
Campylobacteriosis
Cholera
Creutzfeldt-Jakob disease
Cryptococcosis
Cryptosporidiosis
Cyclosporiasis
Diphtheria
E. coli O157:H7
Ehrlichiosis
Encephalitis, any case
Food poisoning and toxicity (includes poisoning by mushroom toxins, ciguatera, scombrotoxin, tetrodotoxin, paralytic shellfish toxin and amnesic shellfish toxin, and other toxins)
Giardiasis
Group A streptococcus, invasive infection
Group B streptococcus, invasive infection
Guillain Barré syndrome
Haemophilus influenzae, invasive infection
Hansen's disease (Leprosy)
Hantavirus infection
Hemolytic uremic syndrome (HUS)
Hepatitis A
Hepatitis B
Hepatitis C
Hepatitis, infectious, not otherwise specified
Influenza
Legionellosis
Leptospirosis
Listeriosis
Lyme disease
Malaria
Measles
Meningitis, bacterial, community-acquired
Meningitis, viral (aseptic) and other infectious (non-bacterial)
Meningococcal disease, invasive infection (*N. meningitidis*)
Monkeypox and infection with any other orthopox virus in humans
Mumps
Pertussis
Plague
Poliomyelitis
Psittacosis
Q Fever

Rabies in humans

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Reye syndrome
Rheumatic fever
Rickettsialpox
Rocky Mountain spotted fever
Rubella
Salmonellosis
Severe Acute Respiratory Syndrome (SARS) and infection with the SARS-associated coronavirus
Shigellosis
Shiga toxin-producing organisms isolated from humans, including enterohemorrhagic *E. coli* (EHEC)
Smallpox
Streptococcus pneumoniae, invasive infection
Tetanus
Toxic shock syndrome
Toxoplasmosis
Trichinosis
Tularemia
Varicella (chickenpox)
Viral hemorrhagic fevers
Yersiniosis

300.110: Case Reports by Local Board of Health

Each local board of health shall report to the Department the occurrence or suspected occurrence of any disease reported to the board of health, pursuant to 105 CMR 300.100. When available, the case's name, date of birth, age, sex, address and disease must be included for each report. The report shall be in a form or manner deemed acceptable by the Department. Each case shall be reported, immediately, but no later than 24 hours of receipt by the local board of health.

300.120: Confidentiality

All personally identifying information, whether kept in an electronic system or paper format, including but not limited to, reports of disease, records of interviews, written or electronic reports, statements, notes, and memoranda, about any individual that is reported to or collected by the Department or local boards of health pursuant to 105 CMR 300.000 *et seq*., shall be protected by persons with knowledge of such identity. Except when necessary for disease investigation, control, treatment and prevention purposes, the Department and local boards of health shall not disclose any personally identifying information without the individual's written consent. Only those Department and local board of health employees who have a specific need to review personal data records for lawful purposes of the Department or local board of health shall be entitled access to such records. The Department and local boards of health shall ensure that all paper records and electronic data systems relating to information that is reported to or collected by the Department or local boards of health pursuant to 105 CMR 300.000 *et seq*. are kept secure and, to the greatest extent practical, kept in controlled access areas.

300.130: Prevention of Foodborne Cases of Viral Gastroenteritis

Food handling facility employees who test positive for Norwalk virus, Norwalk-like virus, norovirus, or any other calicivirus shall be excluded from food handling duties for either 72 hours past the resolution of symptoms or 72 hours past the date the positive specimen was provided, whichever occurs last. In outbreak circumstances consistent with Norwalk virus, Norwalk-like virus or other calicivirus infection, affecting patrons or food handlers, food handling facility employees may be required to provide stool specimens for testing.

300.131: Illness Believed to be Due to Food Consumption

Every person who is a health care provider or who is in a supervisory position at a school, day care, hospital, institution, clinic, medical practice, laboratory, labor or other camp who has knowledge of the occurrence or suspected occurrence of a case or cases of illness believed to have been due to the consumption of food, shall report the same immediately by telephone, by facsimile or other electronic means to the local board of health in the community in which the facility is located. If the local board of health is unavailable, contact the Department directly.

300.132: Illness Believed to Be Transmissible Through Food

The manager or supervisor of any food handling facility, when he/she knows or has reason to believe that an employee has contracted any disease transmissible through food or has become a carrier of such disease, shall report the same immediately by telephone, by facsimile or other electronic means to the local board of health in the community in which the facility is located. If the local board of health is unavailable, contact the Department directly.

300.133: Illness Believed to Be Unusual

In addition to the diseases listed in 105 CMR 300.100, every person who is a health care provider or who is in a supervisory position at a school, day care, hospital, institution, clinic, medical practice, laboratory, labor or other camp who has knowledge of the occurrence or suspect case of an unusual illness, shall report the same immediately by telephone, by facsimile or other electronic means to the local board of health in the community in which the facility is located. If the local board of health is unavailable, contact the Department directly.

300.134: Illness Believed to Be Part of an Outbreak or Cluster

In addition to the diseases listed in 105 CMR 300.100, every person who is a health care provider or who is in a supervisory position at a school, day care, hospital, institution, clinic, medical practice, laboratory, labor or other camp who has knowledge of the occurrence of any suspected cluster or outbreak of any illness, shall report the same immediately by telephone, by facsimile or other electronic means to the local board of health in the community in which the facility is located. If the local board of health is unavailable, contact the Department directly.

300.140: Reporting of Animal Diseases with Zoonotic Potential by Veterinarians

As required under M.G.L. c. 129, § 28 any veterinarian or local board of health with knowledge of an animal disease potentially infectious to humans must report the disease to the Department of Food and Agriculture (DFA), Bureau of Animal Health. DFA will immediately notify the Department of any potential occurrence of such zoonotic disease. Notwithstanding requirements to report such cases to DFA, veterinarians shall also report to the Department within 24 hours any case of anthrax, plague, West Nile virus infection, or Eastern equine encephalitis virus infection diagnosed in an animal. The Department will notify the local board of health of all such reports within 24 hours of receipt.

300.150: Declaring a Disease or Condition Immediately Reportable, Under Surveillance and/or Subject to Isolation and Quarantine: Temporary Reporting, Surveillance and/or Isolation and Quarantine

In addition to the diseases and conditions listed in 105 CMR 300.000 *et seq*., the Commissioner, as necessary to reduce morbidity and mortality in the Commonwealth, shall require the reporting, authorize the surveillance and/or establish isolation and quarantine requirements, on a time-limited basis, of confirmed and suspect cases of diseases or conditions which are newly recognized or recently identified or suspected as a public health concern. Such declarations shall be authorized for a period of time not to exceed 12 months. Such requirements for a particular disease or condition beyond this time period shall be continued pursuant to 105 CMR 300.000 *et seq*.

300.160: Diseases Reportable by Local Boards of Health to the Department

Whenever there shall occur in any municipality report of a case of unusual illness or cluster or outbreak of disease, including but not limited to suspected food poisoning, or an increased incidence of diarrheal and/or unexplained febrile illness, it shall be the duty of the local board of health to report immediately by telephone, by facsimile, or other electronic means the existence of such an unusual disease, outbreak, cluster, or increased incidence of illness to the Department.

300.170: Laboratory Findings Indicative of Infectious Disease Reportable Directly to the Department by Laboratories

In addition to the requirements of 105 CMR 300.100, 300.171, 300.180(A) and 300.180(C) all laboratories, including those outside of Massachusetts, performing examinations on any specimens derived from Massachusetts residents that yield evidence of infection due to the organisms listed below shall report such evidence of infection directly to the Department by telephone, in writing, by facsimile or other electronic means, as deemed acceptable by the Department within 24 hours. Laboratory assays that demonstrate immunity only shall not be reported. A laboratory contact must be included with each report in addition to the test results, date of specimen collection, case's full name, date of birth, sex, address, and name of principal health care provider, when available. Selected isolates, according to guidelines published by the Department, shall be submitted concurrently to the State Laboratory Institute for further examination. Upon receipt of a laboratory report, the Department shall notify the local board of health in the town in which the case resides within one day by telephone, in writing, by fascimile or other electronic means, as deemed acceptable by the Department. If the case's address is not available, the local board of health in the town where the diagnosis is made shall be notified.

Arborviruses, including but not limited to, Eastern equine encephalitis virus, dengue fever virus, West Nile virus and yellow fever virus

Babesia sp.
Bacillus anthracis
Bordetella pertussis
Borrelia burgdorferi
Brucella sp.
Caliciviruses including but not limited to Norwalk virus and Norwalk-like virus
Calymmatobacterium (Donovania) granulomatis
Campylobacter sp.
Chlamydia psittaci
Chlamydia trachomatis (ophthalmic, genital and neonatal infections, lymphogranuloma venereum)
Clostridium tetani
Corynebacterium diphtheriae
Coxiella burnetii
Cryptococcus neoformans
Cryptosporidium parvum
Cyclospora cayetanensis
Ehrlichia sp.
Entamoeba histolytica
Enteroviruses
Escherichia coli O157:H7
Francisella tularensis
Giardia lamblia
Group A streptococcus, from a usually sterile site
Group B streptococcus, from a usually sterile site
Haemophilus ducreyi
Haemophilus influenzae, from a usually sterile site
Hantavirus
Hepatitis A virus
Hepatitis B virus
Hepatitis C virus
Herpes simplex virus, neonatal infection (in child < 30 days old)
Human papilloma virus
Evidence of human prion disease

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Influenza A and B viruses
Legionella sp.
Leptospira sp.
Listeria sp.
Measles virus
Monkeypox virus and evidence of infection with any other orthopox virus in humans
Mumps virus
Mycobacterium leprae
Mycobacterium tuberculosis, M. africanum, M. bovis
Neisseria gonorrhoeae
Neisseria meningitidis, from a usually sterile site
Plasmodium falciparum, P. malariae, P. ovale. P. vivax
Poliovirus
Rickettsia akari
Rickettsia rickettsii
Rubella virus
Salmonella sp.
SARS-associated coronavirus
Shiga toxin-producing organisms
Shigella sp.
Streptococcus pneumoniae, from a usually sterile site
Toxoplasma gondii, Toxoplasma sp.
Treponema pallidum
Trichinella spiralis
Varicella virus
Vibrio sp.
Yersinia pestis
Yersinia sp.

300.171: Reporting of Antimicrobial Resistant Organisms

The Department shall require laboratories to report results indicating antimicrobial resistance in specific organisms. Information requested shall include the name of a laboratory contact, the specified test results, date of specimen collection, source of specimen, and the case's full name, date of birth, sex, full address, and name of principal health care provider, when available. Selected isolates, as specified by the Department, shall also be required to be submitted directly to the State Laboratory Institute for further examination. Reports of antimicrobial resistant organisms shall include, but are not limited to, the following:

Neisseria gonorrhoeae resistant to fluoroquinolones or ceftriaxone
Vancomycin-resistant *Staphylococcus aureus* (VRSA)
Vancomycin-intermediate *Staphylococcus aureus* (VISA)
Invasive penicillin-resistant *Streptococcus pneumoniae*

If antimicrobial resistance of an unexplained or novel nature is identified in any infectious organism, the laboratory must contact the Department within five business days.

300.180: Diseases Reportable Directly to the Department

(A) Reporting of Active or Suspect Active Tuberculosis Disease. Any health care provider, laboratory, board of health or administrator of a city, state or private institution or hospital who has knowledge of a case of confirmed tuberculosis or clinically suspected tuberculosis, as defined in 105 CMR 365.004, shall notify the Division of Tuberculosis Prevention and Control in the Department within 24 hours. This notice shall include at a minimum, the case name, date of birth, sex and address, and the name and telephone number of the person reporting the case. Upon receipt of such notice, the Division of Tuberculosis Prevention and Control shall notify the local board of health in the community where the case resides within 24 hours.

(B) Reporting of Latent Tuberculosis Infection (Positive Tuberculin Skin Test). Any health care provider, board of health or administrator of a city, state or private institution or hospital who has knowledge of a case of latent tuberculosis infection (LTBI), as diagnosed by a tuberculin skin test performed with purified protein derivative (PPD) antigen by the Mantoux

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method, or by any other diagnostic test approved for this purpose by the federal Food and Drug Administration, that results in a reaction that represents a positive test according to the most recently published guidelines of the U.S. Centers for Disease Control and Prevention, shall notify the Division of Tuberculosis Prevention and Control in the Department in a written or electronic format as designated by the Department, with information regarding the name and address of the individual, date of birth, gender, size of the positive skin test or alternative test result, treatment initiated and, as requested by the Department, information about risk of exposure to tuberculosis.

(C) The diseases listed below shall be reported directly to the Department by household members, physicians and other health care providers, laboratories and other officials designated by the Department, by telephone, in writing, by facsimile or other electronic means, as deemed acceptable by the Department. Each report shall be submitted no more than 24 hours after diagnosis or identification.

Acquired immunodeficiency syndrome (AIDS)
Chancroid
Chlamydial infection (genital)
Genital warts
Gonorrhea
Granuloma inguinale
Herpes simplex infection, neonatal (onset within 30 days after birth)
Lymphogranuloma venereum
Ophthalmia neonatorum caused by any agent
Pelvic inflammatory disease of any etiology
Syphilis

(D) Infection with Human Immunodeficiency Virus (HIV). HIV infection, as determined by a laboratory test diagnostic of HIV infection, shall be reported directly to the department by health care providers, as defined in M.G.L. c. 111, § 1, or other officials designated by the Department, in a form and manner designated by the Department, using a non-name reporting system as defined in 105 CMR 300.020. Each report of newly identified infection shall be submitted no more than 24 hours after diagnosis or identification.

(E) The following work-related diseases and injuries are reportable directly to the Department by physicians and other health care providers in a manner approved by the Department no later than ten days after diagnosis or identification. Said report must include, as a minimum, the reporter's name and address; the patient's name, address, telephone number, age and sex; race, if known; the employer's name and location where the occupational exposure or injury reportably occurred; the diagnosis of the disease or description of the injury; the patient's occupation if known; and any other information as requested by the Department.

(1) Occupational Lung Disease.
   (a) Asbestosis
   (b) Silicosis
   (c) Beryllium Disease
   (d) Chemical Pneumonitis
   (e) Asthma caused by or aggravated by workplace exposures
(2) Work-related Heavy Metal Absorption.
   (a) Mercury (blood >15 mcg/L: urine > 35 mcg/grams creatinine)
   (b) Cadmium (blood > 5mcg/L: urine > five mcg/grams creatinine)
   (c) Other
(3) Work-related Acute Chemical Poisoning.
   (a) Carbon Monoxide Poisoning
   (b) Pesticide Poisoning
   (c) Other
(4) Work-related Carpal Tunnel Syndrome.

(F) Reporting of Work-related Traumatic Injuries to a Person Less than 18 Years of Age.
(1) By Health Care Facilities. Work-related traumatic injuries to persons less than 18 years of age that are treated in a hospital or other health care facility shall be reported by the

person in charge of the facility or their designee. Health care facilities shall report these cases

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through computer generated reports on a regular basis no less than once every six months. Said reports shall include similar information to that required under 105 CMR 300.140(B).
(2) By Physicians and Other Health Care Providers. Serious work-related traumatic injuries to persons less than 18 years of age shall be reported to the Department by the physician or other health care provider who treats the minor, within ten days after the physician or health care provider initially treats the injury. Physicians and other health care providers may report all work-related traumatic injuries to persons under 18 years of age. Said reports shall include similar information to that required under 105 CMR 300.140(B).

300.181: Reporting Work-related Disease Outbreaks

Any physician or other health care provider who shall have knowledge of a work-related disease outbreak, regardless of whether or not the disease is included on the reportable disease list, shall report it immediately by telephone, in writing, by facsimile, or other electronic means to the Department.

300.182: Joint Authority with Department of Labor and Workforce Development

The Department recognizes that the Department of Labor and Workforce Development also has the authority, pursuant to M.G.L. c.149, § 11, to require reporting of work-related diseases and conditions. In order to avoid duplicate reporting, the Department will, upon designation by the Department of Labor and Workforce Development, also serve as the agent of the Department of Labor and Workforce Development for collection of reports of work-related diseases and conditions required under M.G.L. c. 149, § 11.

300.190: Surveillance and Control of Diseases Dangerous to the Public Health

The Department and local boards of health are authorized to conduct surveillance activities necessary for the investigation, monitoring, control and prevention of diseases dangerous to the public health. Such activities shall include, but need not be limited to:

(A) Systematic collection and evaluation of morbidity and mortality reports.

(B) Investigation into the existence of diseases dangerous to the public health in order to determine the causes and extent of such diseases and to formulate prevention and control measures.

(C) Identification of cases and contacts.

(D) Counseling and interviewing individuals as appropriate to assist in positive identification of exposed individuals and to develop information relating to the source and spread of illness.

(E) Monitoring the medical condition of individuals diagnosed with or exposed to diseases dangerous to the public health.

(F) Collection and/or preparation of data concerning the availability and use of vaccines, immune globulins, insecticides and other substances used in disease prevention and control.

(G) Collection and/or preparation of data regarding immunity levels in segments of the population and other relevant epidemiological data.

(H) Ensuring that diseases dangerous to the public health are subject to the requirements of 105 CMR 300.200 and other proper control measures.

300.191: Access to Medical Records and Other Information

The Department and local boards of health are authorized to obtain, upon request, from health care providers and other persons subject to the provisions of 105 CMR 300.000 *et seq*., medical records and other information that the Department or the local board of health deems necessary to carry out its responsibilities to investigate, monitor, prevent and control diseases dangerous to the public health.

300.192: Surveillance of Diseases Possibly Linked to Environmental Exposures

The Department is authorized to collect from health care providers and other persons subject to 105 CMR 300.000 *et seq.,* and/or prepare data, as detailed in 105 CMR 300.190 and 105 CMR 300.191, on individuals evaluated for or diagnosed with the following diseases possibly linked to environmental exposures:

Amyotrophic Lateral Sclerosis (ALS)
Aplastic Anemia
Asthma
Autism Spectrum Disorder (ASD)
Multiple Sclerosis (MS)
Myelodysplastic Syndrome (MDS)
Scleroderma
Systemic Lupus Erythematosus

300.200: Isolation and Quarantine Requirements

Upon the report of a case or suspected case of disease declared dangerous to the public health, the local board of health and the Department are authorized to implement and enforce the requirements outlined in 105 CMR 300.200. Minimum requirements for the isolation and quarantine of diseases dangerous to the public health are set forth in the following table.

(A) Diseases Reportable to Local Boards of Health.

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Amebiasis	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing one negative stool specimen. If a case has been treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy. In outbreak circumstances, a second consecutive negative stool specimen will be required prior to returning to food handling duties.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handling facility employees shall be required to produce two negative stool specimens 24 hours apart. Otherwise, no restrictions.
Anthrax	For cutaneous anthrax, place on contact precautions until lesions are healed or free from anthrax bacilli.	No restrictions
Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Arbovirus infection	No restrictions	No restrictions
Babesiosis	No restrictions except appropriate exclusion from blood donation.	No restrictions
Botulism	No restrictions	No restrictions
Brucellosis	No restrictions	No restrictions
Campylobacteriosis	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing one negative stool specimen. If a case has been treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy. In outbreak circumstances, a second consecutive negative stool specimen will be required prior to returning to food handling duties.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handling facility employees shall be required to produce two negative stool specimens 24 hours apart. Otherwise, no restrictions.

300.200: continued

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Cholera	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing one negative stool specimen. If a case has been treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion.
Creutzfeldt-Jakob disease	No restrictions	No restrictions
Cryptococcosis	No restrictions	No restrictions
Cryptosporidiosis	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing one negative stool specimen. If a case has been treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy. In outbreak circumstances, a second consecutive negative stool specimen will be required prior to returning to food handling duties.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handling facility employees shall be required to produce two negative stool specimens 24 hours apart. Otherwise, no restrictions.
Cyclosporiasis	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing one negative stool specimen. If a case has been treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handling facility employees shall be required to produce one negative stool specimen. Otherwise, no restrictions.
Diphtheria	Maintain isolation until two successive pairs of nose and throat cultures (and cultures of skin lesions in cutaneous diphtheria) obtained $\geq$ two weeks after completion of antimicrobial therapy and $\geq$ 24 hours apart are negative. If there was no antimicrobial therapy, these two sequential pairs of cultures shall be taken after symptoms resolve and $\geq$ two weeks after their onset. If an avirulent (nontoxigenic) strain is documented, isolation is not necessary.	Contacts whose occupations involve handling food must be excluded from that work until two successive pairs of nose and throat cultures obtained $\geq$ two weeks after completion of anti-microbial prophylaxis (if any) and $\geq$ 24 hours apart are negative. Additional control measures may be recommended by the Department.
E. coli O157:H7	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing two negative stool specimens, taken at least 48 hours apart. If a case was treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handling facility employees shall be required to produce two negative stool specimens 24 hours apart. Otherwise, no restrictions.
Ehrlichiosis	No restrictions	No restrictions

Encephalitis, any case	No restrictions	No restrictions
Food poisoning and toxicity	No restrictions	No restrictions
Giardiasis	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing one negative stool specimen. If a case has been treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy. In outbreak circumstances, a second consecutive negative stool specimen will be required prior to returning to food handling duties.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handling facility employees shall be required to produce two negative stool specimens 24 hours apart. Otherwise, no restrictions.
Group A streptococcus, invasive infection	Persons with streptococcal pharyngitis or skin infections, with or without invasive disease, shall not return to school or child care until at least 24 hours after initiating antimicrobial treatment.	Personal surveillance and prophylaxis with an antimicrobial when appropriate. Otherwise, no restrictions.
Group B streptococcus, invasive infection	No restrictions	No restrictions
Guillain Barré syndrome	No restrictions	No restrictions
Haemophilus influenzae, invasive infection		
a) type B	Until 24 hours after initiating antimicrobial treatment.	Personal surveillance and prophylaxis with an appropriate antimicrobial when indicated by clinical situation of the contact or potential for future transmission. Otherwise, no restrictions.
b) non type B	No restrictions	No restrictions
Hansen's disease	No restrictions if under medical care.	No restrictions
Hantavirus infection	No restrictions	No restrictions
Hemolytic uremic syndrome	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing two negative stool specimens, taken at least 48 hours apart. If a case was treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handling facility employees shall be required to produce two negative stool specimens 24 hours apart. Otherwise, no restrictions.
Hepatitis A	Until one week after onset of symptoms or until end of febrile period, whichever is later.	No restrictions except for susceptible food handling facility employees, who shall be excluded from their occupations for 28 days unless they receive a prophylactic dose of Immune Globulin (IG) within 14 days of first exposure.
Hepatitis B	No restrictions except for exclusion from organ and blood donation. Case shall receive counseling to modify activities in order to prevent transmission.	Personal surveillance for high-risk contacts who should receive Hepatitis B immune globulin (HBIG) and vaccine. Infants born to infected women should also receive HBIG and vaccine. Otherwise, no restrictions.

Hepatitis C	No restrictions except for exclusion from organ and blood donation. Case shall receive counseling to modify activities in order to prevent transmission.	Personal surveillance for high-risk contacts. Otherwise, no restrictions.
Hepatitis- infectious, not otherwise specified	Until documented that illness is not transmissible by fecal oral route or until one week after symptom onset, which ever occurs first. Exclusion from organ and blood donation. Case shall receive counseling to modify activities in order to prevent transmission as appropriate.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. Personal surveillance for high-risk contacts.
Influenza	No restrictions	No restrictions
Legionellosis	No restrictions	No restrictions
Leptospirosis	No restrictions	No restrictions
Listeriosis	No restrictions	No restrictions
Lyme Disease	No restrictions	No restrictions
Malaria	No restrictions except for exclusion from blood donation.	No restrictions
Measles	Through four days after onset of rash (counting the day of rash onset as day zero).	Students and staff born in or after 1957, who are not appropriately immunized or do not have laboratory evidence of immunity, will be excluded from work or classes from the fifth through the 21st day after their exposure. If exposure was continuous and/or if multiple cases occur, susceptibles will be excluded through the 21st day after rash onset in the last case. Health care workers (or patients), regardless of year of birth, who are not appropriately immunized or do not have laboratory evidence of immunity will be excluded from work (or isolated) from the fifth day after their first exposure through the 21st day after their last exposure. These restrictions remain even if the contact received IG. Additional control measures may be recommended by the Department.
Meningitis a) bacterial, community-acquired	If infected with *H. influenzae* or *N. meningitidis*, until 24 hours after initiation of appropriate antibiotic therapy. Otherwise, no restrictions.	Personal surveillance and antibiotic prophylaxis, where appropriate, if case has *H. influenzae* or *N. meningitidis*. Otherwise, no restrictions.
b) viral (aseptic), and other non-bacterial	No restrictions	No restrictions
Meningococcal disease, invasive infection	Until 24 hours after initiation of appropriate antibiotic therapy. Otherwise, no restrictions.	Personal surveillance and antibiotic prophylaxis, where appropriate. Otherwise no restrictions.
Monkeypox	Until lesions have dried and crusts have separated. If no lesions, until seven days after onset of fever.	Personal surveillance. Otherwise no restrictions. Additional control measures may be recommended by the Department
Mumps	Through nine days after onset of gland swelling (counting the initial day of gland swelling as day zero).	Students and staff born in or after 1957, who are not appropriately immunized or do not have laboratory

		evidence of immunity, will be excluded from work or classes from the 12th through the 26th day after their exposure. When multiple cases occur, susceptibles need to be excluded through 26 days after the onset of the last case at the school or work-place. Health care workers (or patients), regardless of year of birth, who are not appropriately immunized or do not have laboratory evidence of immunity will be excluded (or isolated) as stated above for students and staff. Additional control measures may be recommended by the Department.
Pertussis	Until 21 days from onset of cough or five days after initiation of appropriate antibiotic therapy.	If the contact is symptomatic, use same restrictions as for cases. If the contact is an asymptomatic healthcare worker not receiving antibiotic prophylaxis, exclude from the workplace for 21 days after last exposure or, if unknown, for 21 days after the onset of the last case in the setting. If the contact is asymptomatic, not a healthcare worker, and exposed within the last 21 days, s/he should receive antibiotic prophylaxis but no exclusion is generally required. In certain situations deemed to be high-risk, the Department may require exclusion of asymptomatic contacts not receiving antibiotic prophylaxis and/or other contacts, and/or may extend the exclusion period beyond 21 days up to a maximum of 42 days.
Plague	For pneumonic plague, droplet precautions until 72 hours after onset of appropriate antibiotic therapy. For bubonic plague, case shall be placed on contact precautions until 48 hours after onset of effective therapy.	Contacts of cases of pneumonic plague should be provided prophylaxis and placed under personal surveillance for seven days; those who refuse prophylaxis shall be placed in isolation and under personal surveillance for seven days.
Poliomyelitis	Place case on enteric precautions for six weeks after onset of symptoms or until poliovirus can no longer be recovered from feces (the number of negative specimens needed will be determined by the Department on a case-by-case basis).	According to Department guidelines, administer an appropriate preparation of polio virus vaccine if the immune status is unknown or incomplete. Otherwise, no restrictions.
Psittacosis	No restrictions	No restrictions
Q Fever	No restrictions	No restrictions
Rabies- human	For duration of illness	Vaccine and prophylaxis of contacts when appropriate. Otherwise, no restrictions.
Reye Syndrome	No restrictions	No restrictions
Rheumatic Fever	Until 24 hours after initiation of antibiotic therapy.	Search for carriers among close contacts and treat with antibiotics. Otherwise, no restrictions.
Rickettsialpox	No restrictions	No restrictions

Rocky Mountain spotted fever	No restrictions	No restrictions
Rubella Congenital	Isolation from susceptible persons for the first year of life or until two cultures of clinical specimens (nasopharyngeal secretions or urine) obtained one month apart after age three months are negative for rubella virus.	No restrictions except for susceptibles, then same as for non-congenital rubella.
Non-Congenital	Until seven days after onset of rash (counting the day of rash onset as day zero).	Students and staff born in or after 1957, who are not appropriately immunized or do not have laboratory evidence of immunity, will be excluded from work or classes from the seventh through the 21st day after their last exposure. When multiple cases occur, susceptibles need to be excluded until 21 days after the onset of the last case at school or workplace. Health care workers (or patients), regardless of year of birth, who are not appropriately immunized or do not have laboratory evidence of immunity will be excluded from work (or isolated) from the seventh through the 21st day after their last exposure. Susceptible health care workers who were vaccinated post-exposure shall be excluded through the 23rd day after last exposure. Additional control measures may be recommended by the Department.
Salmonellosis Not including Typhoid fever	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing one negative stool specimen. If a case was treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy. In outbreak circumstances, a second negative stool specimen will be required prior to returning to food handling duties.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handling facility employees shall be required to produce two negative stool specimens 24 hours apart. Otherwise, no restrictions.
S. typhi (Typhoid fever)	Food handling facility employees may only return to food handling duties after producing three consecutive negative stool specimens each taken no less than 48 hours apart and one month after onset of first symptoms. If one culture is positive, repeat cultures at one month intervals until three consecutive negative cultures are obtained. If the case has been treated with an antimicrobial, the first stool specimen shall not be submitted until 48 hours after cessation of therapy.	All food handling facility employees, symptomatic or asymptomatic, who are contacts of a typhoid case shall be considered the same as a case and handled in the same fashion.
SARS associated coronavirus	Isolate for duration of illness and for at least ten days after resolution of fever, according to the most current recommendations of the U.S. Centers	Asymptomatic contacts should practice personal surveillance for fever and respiratory symptoms and report them to their health care provider

	for Disease Control and Prevention.	immediately should one or the other occur within ten days of the individual's last contact with the case. Febrile contacts or contacts with respiratory symptoms only, shall be treated the same as a case for 72 hours, after which further management shall be in consultation with the local health department or Department.
Shiga toxin-producing organisms	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing two negative stool specimens, taken at least 48 hours apart. If a case was treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handling facility employees shall be required to produce two negative stool specimens 24 hours apart. Otherwise, no restrictions.
Shigellosis	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing two negative stool specimens taken at least 48 hours apart. If a case was treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handling facility employees shall be required to produce two negative stool specimens 24 hours apart. Otherwise, no restrictions.
Smallpox	In conjunction with public health authorities, place case(s) on highest level of isolation to prevent direct contact, droplet contact and airborne exposure until lesions have dried and crusts have separated.	Afebrile contacts shall be placed under fever surveillance (quarantine) for 18 days from the last contact or 14 days from successful vaccination (which ever comes first), with monitoring and recording of temperature twice daily (morning and evening). Febrile contacts with or without rash shall be considered the same as a case and handled in the same fashion (isolation). If no rash develops after five days and the fever is diagnosed as being caused by recent vaccination or some other non-smallpox etiology, contact may be released from isolation to home to continue fever surveillance for 18 days following their last contact with a case or 14 days following successful vaccination (whichever comes first).
Streptococcus pneumoniae, invasive infection	No restrictions	No restrictions
Tetanus	No restrictions	No restrictions
Toxic shock syndrome	No restrictions	No restrictions
Toxoplasmosis	No restrictions	No restrictions
Trichinosis	No restrictions	No restrictions
Tularemia	No restrictions	No restrictions
Varicella (chickenpox)	Until lesions have dried and crusted, or until no new lesions appear, usually by the fifth day.	Susceptible students or staff, who are not appropriately immunized or are without laboratory evidence of

		immunity or a reliable history of chickenpox, shall be excluded from school from the tenth through the 21st days after their last exposure. Neonates born to mothers with active varicella shall be isolated from susceptibles until 21 days of age. Health care workers shall be excluded from their occupations from the tenth through 21st days after their last exposure if they are susceptible. Anyone receiving varicella zoster immune globulin (VZIG) shall extend their exclusion to 28 days post exposure. Otherwise, no restrictions.
Viral hemorrhagic fevers	Place on hemorrhagic fever specific barrier precautions with airborne, contact, and droplet precautions, and double gloving, with strict hand hygiene, impermeable gowns, face shields, eye protection, and leg and shoe coverings until clinical illness has resolved.	Personal surveillance
Yersiniosis	After diarrhea has resolved, food handling facility employees may only return to food handling duties after producing one negative stool specimen. If a case was treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy. In outbreak circumstances, a second negative stool specimen will be required prior to returning to food handling duties.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handling facility employees shall be required to produce two negative stool specimens 24 hours apart. Otherwise, no restrictions.

(B) Diseases Reportable Directly to the Department of Public Health.

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Acquired immunodeficiency syndrome (AIDS)	No restrictions except for appropriate exclusion from blood and organ donation. Case shall receive counseling to modify sexual and other high-risk activities.	For sexual contacts, counseling to modify sexual and other high-risk activities. Otherwise, contact health authorities for latest information.
Chancroid	Case shall receive counseling to modify sexual activities until recommended treatment is completed.	For sexual contacts, counseling to modify sexual activities until the case's treatment regimen is completed. Sexual contacts shall undergo evaluation and preventative treatment as indicated for exposure.
Chlamydial infections (genital)	Case shall receive counseling to modify sexual activities until recommended treatment is completed.	For sexual contacts, counseling to modify sexual activities until the case's treatment regimen is completed. Sexual contacts shall undergo evaluation and preventative treatment as indicated for exposure.
Genital warts	Case shall receive counseling to modify sexual activities until recommended treatment is completed.	For sexual contacts, counseling to modify sexual activities until the case's treatment regimen is completed. Sexual contacts shall undergo

		evaluation and preventative treatment as indicated for exposure.
Gonorrhea	Case shall receive counseling to modify sexual activities until recommended treatment is completed.	For sexual contacts, counseling to modify sexual activities until the case's treatment regimen is completed. Sexual contacts shall undergo evaluation and preventative treatment as indicated for exposure.
Granuloma inguinale	Counseling to modify sexual activities until recommended treatment is completed.	For sexual contacts, counseling to modify sexual activities until the case's treatment regimen is completed. Sexual contacts shall undergo evaluation and preventative treatment as indicated for exposure.
Herpes, neonatal (onset within 30 days after birth)	Until clinical recovery.	No restrictions

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Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
HIV infection	No restrictions except for appropriate exclusion from blood and organ donation. Case shall receive counseling to modify sexual and other high-risk activities.	For sexual contacts, counseling to modify sexual and other high-risk activities. Otherwise, contact health authorities for latest information.
Lymphogranuloma venereum	Case shall receive counseling to modify sexual activities until recommended treatment is completed.	For sexual contacts, counseling to modify sexual activities until the case's treatment regimen is completed. Sexual contacts shall undergo evaluation and preventative treatment as indicated for exposure.
Ophthalmia neonatorum		
a) Gonococcal	For first 24 hours after administration of antibiotic.	No restrictions except for counseling to modify sexual activities of the mother and her sexual contacts until the treatment regimen is completed. Mother and her sexual contacts shall undergo evaluation and preventative treatment as indicated for exposure.
b) other agents	For first 24 hours after administration of antibiotic.	No restrictions except for counseling to modify sexual activities of the mother and her sexual contacts until the treatment regimen is completed. Mother and her sexual contacts shall undergo evaluation and preventative treatment as indicated for exposure.
Pelvic Inflammatory Disease		
a) Gonococcal	Case shall receive counseling to modify sexual activities until recommended treatment is completed.	For sexual contacts, counseling to modify sexual activities until the case's treatment regimen is completed. Sexual contacts shall undergo evaluation and preventative treatment as indicated for exposure.
b) other agents	Case shall receive counseling to modify sexual activities until recommended treatment is completed.	For sexual contacts, counseling to modify sexual activities until the case's treatment regimen is completed. Sexual contacts shall undergo evaluation and preventative treatment

		as indicated for exposure.
Syphilis	Appropriate restriction from blood donation. Case shall receive counseling to modify sexual activities until recommended treatment is completed.	For sexual contacts, counseling to modify sexual activities until the case's treatment regimen is completed. Sexual contacts shall undergo evaluation and preventative treatment as indicated for exposure.
Tuberculosis		
Pulmonary and laryngeal	Until bacteriologically negative based on three consecutive negative sputum smears, submitted within a time period specified in the most current recommendations of the U.S. Centers for Disease Control and Prevention; or until 14 days after the initiation of appropriate effective chemotherapy, provided therapy is continued as prescribed, and there is demonstration of clinical improvement (*i.e.* decreasing cough, reduced fever, resolving lung infiltrates, or AFB smears showing decreasing numbers of organisms).	No restrictions of asymptomatic contacts required.
Extra-pulmonary	No restrictions except for appropriate handling of infected fluids.	No restrictions

(C) Standard Precautions. In addition to the specific practices set out in 105 CMR 300.000, standard precautions should be followed when treating all patients and contacts. The Department adopts, by reference, as standard practice for infection control, the most current version of the guidelines on the prevention of transmission of infection published by the U.S. Centers for Disease Control and Prevention and its Healthcare Infection Control Practices Advisory Committee.

(D) Work-related Diseases and Injuries Reportable Directly to the Department of Public Health. As these diseases are not communicable, each case should be evaluated individually regarding a return to work.

300.300: Required AIDS Education

(A) All individuals:

(1) Receiving counseling or treatment at a drug rehabilitation treatment program either licensed or approved by the Department pursuant to M.G.L. c. 111E, or located in a licensed general hospital;

(2) Receiving counseling or treatment at a sexually transmitted disease (STD) clinic established pursuant to M.G.L. c. 111, § 117; or

(3) Receiving family planning or pre-natal services;

shall be given and have appropriately discussed with them educational materials which have been developed and distributed by the Department regarding the causes, treatment, prevention, symptoms and transmission of AIDS.

(B) It shall be the responsibility of the Director (or the individual occupying a position with the responsibilities similar to a director) or his or her designee at each drug rehabilitation treatment program and STD clinic to ensure that the AIDS educational materials are properly dispensed and appropriately discussed with each individual receiving counseling or treatment at their clinic.

Further, it shall be the responsibility of such Director (or the individual occupying a position with the responsibilities similar to a director), or his or her designee to maintain in conformity

with the laws concerning confidentiality of such records, for each individual receiving counseling or treatment at such clinics, written documentation that each such individual has received and has had appropriately explained to him or her the content of the AIDS educational materials.

300.300: continued

(C) It shall be the responsibility of the primary pre-natal or family planning provider, or his or her designee, to dispense and appropriately discuss the AIDS educational materials with those individuals he or she treats or counsels regarding family planning or pre-natal services.

Further, it shall be the responsibility of the primary pre-natal or family planning provider, or his or her designee, to maintain written documentation that the AIDS educational materials have been properly dispensed and appropriately discussed with each individual the primary care provider has counseled or treated regarding pre-natal care or family planning.

For the purposes of 105 CMR 300.000, "pre-natal services" shall mean those medical services relating to the monitoring and fostering of the health of the mother and fetus.

For the purposes of 105 CMR 300.000, "family planning services" shall mean those services concerning the counseling of individuals on the subject of contraception and reproduction.

For the purposes of 105 CMR 300.000, "primary pre-natal or family planning provider" shall mean a physician, certified nurse mid-wife, or OB/GYN nurse practitioner.

(D) All individuals applying for a certificate of intention of marriage pursuant to M.G.L. c. 207, § 28A shall be given, and have discussed with them, the contents of the AIDS educational materials which have been developed and distributed by the Department.

(E) The Department shall provide the AIDS educational materials to the clerks or registrars responsible for issuing a certificate of intention of marriage pursuant to M.G.L. c. 207, § 28A who shall distribute a copy of the materials to all applicants for a marriage license. Such clerks and registrars shall not be responsible for discussing the AIDS educational materials with marriage license applicants.

It shall be the responsibility of the physician who administers the pre-marital blood test pursuant to M.G.L. c. 207, § 28A, or his or her designee to discuss the AIDS educational materials distributed by the city or town clerks pursuant to M.G.L. c. 207, § 28A.

Further, it shall be the responsibility of such physician, or his or her designee, to maintain written documentation on the pre-marital medical certificate form required pursuant to M.G.L. c. 207, § 28A, that the AIDS educational materials have been discussed with each individual he or she has so tested.

(F) Nothing in 105 CMR 300.000 shall require that individuals receiving treatment or counseling at an STD or drug rehabilitation treatment program, or receiving family planning or pre-natal services or individuals seeking a certificate of intention of marriage, be tested for evidence of infection with the human immunodeficiency virus.

REGULATORY AUTHORITY

105 CMR 300.000: M.G.L. c. 111, §§ 1, 3, 5, 6, 7, 94C, 109, 110, 110B, 111 and 112 and M.G.L. c.111D, § 6.

NON-TEXT PAGE